FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022350

Facility Name: WESLEY VILLAGE HEALTH CARE CENTER

Address: 1200 EAST GRANT ST. (Number) MACOMB (City) 61455 (Zip Code)

County: MCDONOUGH

Telephone Number: 309-833-2123 **Fax #** 309-837-7500

IDPA ID Number: 370996594001

Date of Initial License for Current Owners: 4/14/1980

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SHELLY WARD **Telephone Number:** 309-833-2123

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 4/30/05 (Date)
(Type or Print Name) SHELLY L. WARD
(Title) ADMINISTRATOR/CEO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 4/16/2004

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	47	18,368	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	73	27,884	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,947	3,361		8,308	8
9	SNF/PED					9
10	ICF	9,766	5,937		15,703	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,713	9,298		24,011	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.11%

D. How many bed-hold days during this year were paid by Public Aid? 192 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/14/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,089

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: TAX-EXEMPT Fiscal Year: JAN-DEC

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN] # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	204,706	16,099	5,983	226,788		226,788		226,788			1
2	Food Purchase		170,561		170,561		170,561	(284)	170,277			2
3	Housekeeping	88,534	9,418		97,952	20,411	118,363		118,363			3
4	Laundry	17,419		36,352	53,771		53,771		53,771			4
5	Heat and Other Utilities			86,200	86,200		86,200		86,200			5
6	Maintenance	30,718	15,135	6,768	52,621		52,621		52,621			6
7	Other (specify):*											7
8	**TOTAL General Services**	341,377	211,213	135,303	687,893	20,411	708,304	(284)	708,020			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,226,335	133,601	116,845	1,476,781	(52,417)	1,424,364		1,424,364			10
10a	Therapy											10a
11	Activities	37,019	10,118	8,511	55,648		55,648	(4,250)	51,398			11
12	Social Services					32,006	32,006		32,006			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,263,354	143,719	125,356	1,532,429	(20,411)	1,512,018	(4,250)	1,507,768			16
	C. General Administration											
17	Administrative	58,400			58,400		58,400		58,400			17
18	Directors Fees											18
19	Professional Services			14,268	14,268		14,268	(2,000)	12,268			19
20	Dues, Fees, Subscriptions & Promotions			7,254	7,254		7,254		7,254			20
21	Clerical & General Office Expenses	65,848	23,116		88,964		88,964		88,964			21
22	Employee Benefits & Payroll Taxes			298,462	298,462		298,462		298,462			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,515	11,515		11,515		11,515			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			16,033	16,033		16,033		16,033			26
27	Other (specify):*											27
28	**TOTAL General Administration**	124,248	23,116	347,532	494,896		494,896	(2,000)	492,896			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,728,979	378,048	608,191	2,715,218		2,715,218	(6,534)	2,708,684			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER #0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			118,505	118,505		118,505		118,505			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			94,665	94,665		94,665		94,665			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			213,170	213,170		213,170		213,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,765	41,765		41,765		41,765			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			41,765	41,765		41,765		41,765			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,728,979	378,048	863,126	2,970,153		2,970,153	(6,534)	2,963,619			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	4,250	LN11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	284	LN 2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	2,000	LN 19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 6,534		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	7,222	X-F	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,222		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 13,756		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WESLEY VILLAGE HEALTH CARE CENTER

ID# 0022350

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		NOT APPLICABLE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	NOT APPLICABLE		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		NOT APPLICABLE				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SUBORDINATED DEBENTURES		X				$ 323,005	$ 221,400	VARIOUS	VARIOUS	$ 12,274	1
2	FIRST FEDERAL BANK		X	ANNUAL PAYMENT 11/04			2,725,000	1,724,826	11/13/2022	4.2000	82,391	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,048,005	$ 1,946,226			$ 94,665	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,048,005	$ 1,946,226			$ 94,665	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESLEY VILLAGE HEALTH CARE CENTER COUNTY MCDONOUGH

FACILITY IDPH LICENSE NUMBER 0022350

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,893 B. General Construction Type: Exterior BRICK Frame PRESTRESSED CON(Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

WESLEY VILLAGE RETIREMENT CENTER - 70 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 144,434
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 7,222
4. Dates Incurred: 2/1/1997 - 1/31/1998

Nature of Costs: BOND ISSUANCE EXPENSES - 1998 NEW CONSTRUCTION - ALZHEIMER UNIT
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	235,224	1975	$ 48,600	1
2					2
3	TOTALS	235,224		$ 48,600	3

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	47		1980	1980	$ 1,304,649	$ 25,968	50	$ 25,968	$	$ 640,721	4
5	26		1998	1997	1,934,404	50,214	50	50,214		316,920	5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS										9
10	Paved parking lot			1981	28,080		15			28,080	10
11	Landscaping			1981	2,943		10			2,943	11
12	Landscaping			1984	227		10			227	12
13	Blacktop driveway			1985	559		10			559	13
14	Landscaping, Install cement patio			1982	488		20			488	14
15	Landscaping			1983	681		20			681	15
16	Blacktop driveway			1986	2,668		15			2,668	16
17	Blacktop driveway			1987	15,464		15			15,464	17
18	Improve drainage			1987	1,036		15			1,036	18
19	Landscaping costs			1988	599		10			599	19
20	Improve drainage from roof area			1989	946		15			946	20
21	Blacktop sealer			1990	1,394	93	15	93		1,345	21
22	Blacktop sealer			1991	1,054	71	15	71		949	22
23	Blacktop sealer			1994	1,307	87	15	87		914	23
24	Turf & Garden mix 38%			1997	322	13	10	13		104	24
25	Walking path 50%			1997	418	10	20	10		80	25
26	Concrete Curbing 38%			1997	562	7	20	7		56	26
27	Walking path 50%			2000	17,911	896	20	896		4,480	27
28	Alzheimers Garden enhancement			2000	4,468	223	20	223		1,115	28
29	Walking path			2001	15,264	890	10	890		3,560	29
30	Glider walking path			2002	1,346	135	10	135		270	30
31	Seal & asphalt drive & parking lot			2003	7,888	367	15	367		734	31
32	Landscape gazebo area			2003	1,202	10	10	10		20	32
33	Landscaping around wheelchair swing 50%			2004	856	85	10	85		85	33
34	Landscaping South Garden 50%			2004	5,618	562	10	562		562	34
35	BUILDING IMPROVEMENTS										35
36	Screens & doors			1981	4,500		10			4,500	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Constructed carports	1981	$ 2,000	$ 40	50	$ 40	$	$ 920	37
38	Wallpaper	1981	2,264		20			2,264	38
39	Entrance signs	1981	5,920	208	30	208		4,821	39
40	Signs	1981	58		12			58	40
41	Intangibles	1981	5,742		20			5,742	41
42	Overhang roof drain	1982	342		20			342	42
43	Remodel bathroom	1982	371	8	50	8		176	43
44	Exhaust fans & lights	1982	426		20			426	44
45	Carpet	1983	169		5			169	45
46	Install satellite system	1983	4,122		15			4,122	46
47	Remodeling	1983	389	8	50	8		167	47
48	Wheelchair ramp	1984	407		10			407	48
49	Remodel showers	1984	501	17	30	17		324	49
50	Install decoder	1985	450		15			450	50
51	Redecorate resident rooms	1985	10,126		15			10,126	51
52	Install tornado siren	1986	3,056		15			3,056	52
53	Carpet	1987	538		5			538	53
54	Install TV filter	1987	68		15			68	54
55	Redecorate resident rooms	1987	7,274		15			7,274	55
56	Remodeling hallway	1988	68		15			68	56
57	Roof repair	1989	3,704	246	15	246		3,704	57
58	Emergency light	1989	35		10			35	58
59	Redecorating	1989	13,802	920	15	920		13,173	59
60	Nurse call system	1990	4,919	315	15	315		3,923	60
61	Elevator jack	1990	3,780	240	15	240		3,360	61
62	Solid core door	1990	735		10			735	62
63	Water system repairs	1991	1,410		10			1,410	63
64	Water heater repairs	1991	1,323		10			1,323	64
65	Replace window panes	1991	9,051	476	20	476		6,413	65
66	Install A/C food service	1992	866	43	20	43		559	66
67	Roof repairs	1992	8,685	579	15	579		7,527	67
68	Redesign water system	1992	2,385	95	20	95		1,140	68
69	Remodeling	1992	9,845	656	15	656		7,872	69
70	TOTAL (lines 4 thru 69)		$ 3,461,685	$ 83,482		$ 83,482	$	$ 1,122,798	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,461,685	$ 83,482		$ 83,482	$	$ 1,122,798	1
2	Carpeting	1993	851	57	15	57		655	2
3	Remodeling	1993	1,540		10			1,540	3
4	New entryway	1994	7,888	484	20	484		4,985	4
5	Remodeling	1994	3,216	322	10	322		2,898	5
6	Painting entryway & carpet	1995	2,456	246	10	246		2,408	6
7	Dining room floor	1996	116	6	20	6		49	7
8	Roof repairs - west end	1996	385	26	15	26		223	8
9	12 Air conditioner units	1996	3,698	247	15	247		1,791	9
10	Shingle east entrance	1997	398	26	15	26		189	10
11	Border resident rooms	1997	484	25	10	25		179	11
12	Carpet installations - hallway	1997	265	13	20	13		93	12
13	Vinyl floor covering corridor	1997	1,507	75	20	75		525	13
14	Remote annunicator panel	1997	705	34	20	34		256	14
15	Heating/Air conditioning units	1997	1,602	80	20	80		567	15
16	3 Windows	1997	116	6	20	6		43	16
17	12 Window screens	1997	126	6	20	6		45	17
18	Carpet	1997	432	36	20	36		252	18
19	Drainage from SE corner of building	1997	378	24	15	24		181	19
20	Additional wiring to pass inspection	1998	4,748	237	20	237		1,561	20
21	Window treatments	1998	10,940	547	20	547		3,647	21
22	Mixing valve	1998	2,695	180	15	180		1,110	22
23	Tuckpointing building exterior	1998	4,511	180	20	180		1,110	23
24	Flooring	1998	665	44	15	44		305	24
25	New fire alarms in health care	1998	10,468	523	20	523		3,226	25
26	Additional strobes due to inspection	1998	1,381	69	20	69		466	26
27	Roof repairs kitchen & SE section	1998	9,060	362	25	362		1,901	27
28	Alzheimer unit lounge flooring	1999	1,074	54	15	54		324	28
29	Health care lighting upgrade	1999	2,019	135	10	135		810	29
30	Fire alarm upgrade	1999	2,814	164	10	164		984	30
31	Heating/cooling laundry room & kitchen corridor	2000	9,000	450	20	450		2,250	31
32	Sewer line	2000	8,868	355	25	355		1,775	32
33	Smoking patio	2000	2,590	130	20	130		650	33
34	TOTAL (lines 1 thru 33)		$ 3,558,681	$ 88,625		$ 88,625	$	$ 1,159,796	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,558,681	$ 88,625		$ 88,625	$	$ 1,159,796	1
2	Decorate Health care dining room	2001	7,887	307	15	307		1,228	2
3	A/C compressor health care core	2001	9,076	202	15	202		808	3
4	Wall guards health care dining room	2001	970	32	15	32		128	4
5	Kitchen walk-in cooler compressor	2001	1,769	253	7	253		1,012	5
6	Generator health care	2001	989	24	7	24		96	6
7	Alzheimers water system	2001	14,079	469	20	469		1,876	7
8	Glider walking path	2002	1,346	135	10	135		405	8
9	Storage shed - cement work	2002	9,357	468	20	468		1,404	9
10	Health care core area roof	2002	8,800	440	20	440		1,320	10
11	Outside doors - HC center hall	2003	5,600	560	10	560		1,120	11
12	Health care center shower room tile	2003	1,475	147	10	147		294	12
13	Health care center core area remodeling	2003	1,000	100	10	100		200	13
14	Water softening system	2003	12,470	1,247	10	1,247		2,494	14
15	Garage/storage	2003	17,861	893	20	893		1,786	15
16									16
17	Health care center dining room remodeling	2004	27,065	1,804	15	1,804		1,804	17
18	Health care center core area floor plans - architect	2004	7,414	494	15	494		494	18
19	Garage/storage 50%	2004	1,737	87	20	87		87	19
20	Carpet - 7 rooms Health care	2004	3,910	260	15	260		260	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,691,486	$ 96,547		$ 96,547	$	$ 1,176,612	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 631,669	$ 18,880	$ 18,880	$		$	71
72	Current Year Purchases	30,781	3,078	3,078				72
73	Fully Depreciated Assets	3,784						73
74								74
75	TOTALS	$ 666,234	$ 21,958	$ 21,958	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,406,320	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 118,505	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 118,505	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,176,612	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 115,249	$ 192,082	1
2	Cash-Patient Deposits		336,447	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)	24,655	40,777	4
5	Short-Term Investments	825,791	1,362,420	5
6	Prepaid Insurance	9,699	19,021	6
7	Other Prepaid Expenses		27,861	7
8	Accounts Receivable (owners or related parties)		146,398	8
9	Other(specify):		50,027	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 975,394	$ 2,175,033	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	190,178	279,674	12
13	Land	48,600	360,000	13
14	Buildings, at Historical Cost	3,644,887	7,756,140	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	627,885	1,273,102	16
17	Accumulated Depreciation (book methods)	(1,571,132)	(3,881,420)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	144,304		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(50,554)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,034,168	$ 5,787,496	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,009,562	$ 7,962,529	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 25,166	$ 41,943	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED EXPENSES	154,850	232,309	36
37	MEMBER FEE,APT DEPOSITS	230,565	577,026	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 410,581	$ 851,278	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	223,155	820,000	39
40	Mortgage Payable	1,916,473	2,452,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,139,628	$ 3,272,500	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,550,209	$ 4,123,778	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,459,353	$ 3,838,751	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,009,562	$ 7,962,529	48

***(See instructions.)**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,812,752	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,812,752	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(353,399)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (353,399)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,459,353	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,496,865	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,496,865	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	119,889	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 119,889	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,616,754	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	687,893	31
32	Health Care	1,532,429	32
33	General Administration	494,896	33
	B. Capital Expense		
34	Ownership	213,170	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	41,765	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,970,153	40
41	**Income before Income Taxes (line 30 minus line 40)****	(353,399)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (353,399)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,120	$ 46,500	$ 21.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,509	6,810	139,877	20.54	3
4	Licensed Practical Nurses	17,085	18,071	335,506	18.57	4
5	Nurse Aides & Orderlies	56,024	59,257	581,904	9.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,120	22,000	10.38	9
10	Activity Assistants	2,000	2,244	18,519	8.25	10
11	Social Service Workers	1,956	2,080	32,006	15.39	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,080	26,000	12.50	13
14	Head Cook	2,122	2,400	22,800	9.50	14
15	Cook Helpers/Assistants	14,500	15,300	106,405	6.95	15
16	Dishwashers	7,000	7,500	49,501	6.60	16
17	Maintenance Workers	2,100	2,200	30,718	13.96	17
18	Housekeepers	11,250	11,675	88,534	7.58	18
19	Laundry	2,410	2,515	17,419	6.93	19
20	Administrator	1,960	2,080	58,400	28.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,821	5,366	65,848	12.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,500	3,700	42,532	11.50	31
32	Other Health Care(specify)					32
33	Other(specify) UNIT COOR	2,190	2,320	44,510	19.19	33
34	TOTAL (lines 1 - 33)	141,363	149,838	$ 1,728,979 *	$ 11.54	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	172	$ 4,448	LN 1 COL 3	35
36	Medical Director				36
37	Medical Records Consultant	4	100	LN 10 COL 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	3,300	LN 10 COL3	39
40	Physical Therapy Consultant	21	1,123	LN 10A COL	40
41	Occupational Therapy Consultant	4	200	LN10A COL3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	25	LN10A COL3	43
44	Activity Consultant	10	715	LN11 COL3	44
45	Social Service Consultant	10	715	LN10A COL3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	233	$ 10,626		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY WARD		0	$ 58,400
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,400

B. Administrative - Other

Description	Amount
NOT APPLICABLE	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
CLIFTON-GUNDERSON	AUDIT/ACCOUNTING	$ 9,768
MARCH & MCMILLAN	LEGAL	2,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 12,268

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,771
Unemployment Compensation Insurance	
FICA Taxes	124,641
Employee Health Insurance	111,050
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 298,462

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,975
Health Care Worker Background Check	1,111
(Indicate # of checks performed)	
DUES - SEE ATTACHED SCHEDULE	4,168
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,254

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,515
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,515

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3	NOT APPLICABLE												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LIFE SERVICES NETWORK**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **YES** If YES, what is the capacity? **73**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,629** Line **10 COL 3**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,765**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CLIFTON-GUNDERSON & CO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **FINAL COPY NOT RECEIVED TO**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.